



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDME SERVICES CORPORATION
PO BOX 920173
EL PASO TX 79902

Respondent Name

Hartford Underwriters Insurance

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-4841-01

MFDR Date Received

August 15, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This item was paid at the Rental Fee Sch. The purchase allows \$469.56 as with the TENS."

Amount in Dispute: \$352.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Acknowledgement of medical fee dispute received however, no written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2011	Durable Medical Equipment	\$352.18	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – NEUROMUSCULAR STIMULATOR ELECTRONIC SHOCK UNIT
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.

Issues

1. Did the requestor submit the bill with correct code and modifiers?

2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202 states, in pertinent part “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section and “(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate American Medical Association (AMA) Physician's Current Procedural Terminology(CPT) code. Additionally, commission specific modifiers are identified in paragraph (9) of this subsection. When two modifiers are applicable to a single CPT code, indicate each modifier on the bill.” Review of the submitted documentation finds HCPCS code E0745 – NU was submitted on claim line. Per DMEPOS Fee Schedule the service in dispute is classified as “Capped Rental” as such purchase in the first month is not allowed but rather per CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5 “For these items of DME, contractors pay the fee schedule amounts on a monthly rental basis not to exceed a period of continuous use of 15 months.” Therefore, the division finds purchase in the first month cannot be allowed.
2. The insurance carrier made a payment, the applicable division rule is 28 Texas Administrative Code §134.203 (c) states, “To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:”
 - a. (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used.
 - b. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L:
 - c. (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

Therefore the total MAR is calculated as follows DMEPOS fee schedule \$93.90 x 125% = \$117.36. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December , 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box

17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.